

Issue Brief

Physician-Assisted Dying

December 17, 2015

Background

- On February 6, 2015, the Supreme Court of Canada issued a historic ruling in the case of Kathleen Carter and Gloria Taylor ([Carter v. Canada](#)) on the issue of physician-assisted death.
- The Court said that the Criminal Code's provisions prohibiting assisted dying [s. 241(b) and s.14] infringed section 7 of the Charter of Rights and Freedoms, which guarantees the right to life, liberty and security of the person.
- The provisions were found to be of "no force and effect" to the extent that they prohibit physician-assisted death for:
 - a competent adult
 - who clearly consents to the termination of life
 - has a grievous and irremediable medical condition (including an illness, disease or disability)
 - that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition.
- With respect to conscientious objection, the Supreme Court said that, "[n]othing in this declaration would compel physicians to provide assistance in dying. The Charter rights of patients and physicians will need to be reconciled in any legislative and regulatory response to this judgment."
- The Supreme Court of Canada said that Parliament must have the opportunity to craft an appropriate response. It suspended its ruling for one year to give the federal government time to come up with an amended law (or not) and to allow provincial governments and regulators to prepare. On February 6, 2016 (one year after the ruling), physician-assisted dying will be legal in Canada (in the absence of an extension from the Supreme Court of Canada). In the interim, the current criminal law (that is, an absolute prohibition on assisted dying) remains in effect.

Issue

On February 6, 2015, the Supreme Court of Canada issued a historic ruling in the case of Kathleen Carter and Gloria Taylor (*Carter v. Canada*) on the issue of physician-assisted death.

The purpose of this brief is to provide an update on the *Carter* decision as well as an update on selected initiatives in response to the decision.



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- On December 2, 2015, the federal government asked the Supreme Court of Canada for a six-month extension of the period before the *Carter* case ruling comes into force to draft new laws. In its formal request, the government indicated that a comprehensive response to the *Carter* legal decision requires extensive work by Parliament and provincial legislatures, and cannot reasonably be completed before February 6, 2016 (as noted above, this is the date that physician-assisted dying will be legal in Canada - as set out in the '*Carter*' case - in the absence of an extension from the Supreme Court). The Supreme Court has not yet responded to the request for more time.
- On December 15, 2015, The Honourable Jody Wilson-Raybould, Minister of Justice and Attorney General of Canada, along with the Honourable Dr. Jane Philpott, Minister of Health, announced that Parliament has agreed to establish an all-party Special Joint Committee on physician-assisted dying. The Committee will consult with experts, stakeholders and Canadians in general and make recommendations on the framework of a federal response on physician-assisted dying by the end of February. The Federal government is reportedly planning to have a new law crafted, studied, debated and passed by June 2016.
- About 84 percent of Canadians support the right to die, according to a poll commissioned by Dying with Dignity. Doctors are also generally supportive – however, not all of them are willing to engage in physician-assisted dying. According to a summer 2015 poll commissioned by the Canadian Medical Association, only 29 percent of Canadian physicians said they would be willing to assist a gravely ill patient who wants to end their life.

Current Situation

A number of initiatives are ongoing in response to the *Carter* decision, including the following:

- **Federal External Panel on Options for a Legislative Response to *Carter v. Canada*:** In July 2015, the Government of Canada (under former Prime Minister, Stephen Harper) established an [External Panel on Options for a Legislative to *Carter v. Canada*](#). The original mandate of the panel was to engage Canadians and key stakeholders on issues the federal government will need to consider in response to the *Carter* ruling. The Panel was initially tasked with providing a final report to Ministers of Justice and Health that will outline key findings and options for consideration by the Ministers.

The three panel members were: Catherine Frazee, Professor Emerita at Ryerson University and advocate for full social inclusion of people with disabilities; Dr. Harvey Max Chochinov, Distinguished Professor of Psychiatry at the University of Manitoba and Director of the Manitoba Palliative Care Research Unit; and, Benoit Pelletier, Law Professor, University of Ottawa.

The Panel consulted directly with 66 experts through 51 meetings in five countries, and 95 representatives from 48 Canadian organizations. The Panel received over 300 document submissions from stakeholders and over 11,000 responses to its online consultation.

On November 15, 2015, the Honourable Jody Wilson-Raybould (Minister of Justice and Attorney General of Canada) and the Honourable Dr. Jane Philpott, Minister of Health, extended the Panel's [mandate](#) by one month to December 15, 2015, to allow the Panel to complete its report. The Panel's mandate was also modified to focus on the results of the consultations, rather than on the development of legislative options. The Panel's 134-page report was delivered to the federal government on December 15, 2015 and is currently being reviewed and translated. It is expected to be released publicly early in the new year. On December 15, 2015, the federal government indicated that the all-Party Special Joint Committee on physician-assisted dying (see above) will review the report from the Federal External Panel.

- **Provincial/Territorial Expert Advisory Group on Physician-Assisted Dying, under the lead of the Ontario Ministry of Health and Long-Term Care:** The provinces, led by Ontario, appointed their own consultative committee. The mandate of this group was to provide non-binding advice to participating Provincial-Territorial Ministers of Health and Justice on issues related to physician-assisted dying. The advice is meant to assist provinces and territories in deciding what policies and procedures should be implemented within their jurisdictions in response to the *Carter* decision.

After three months of consultations with experts and organizations from across Canada, and with input from 11 of the 13 provinces and territories, the Advisory Group released a report on December 14th 2015 containing 43 recommendations in total (the report is dated November 30, 2015, but public release was on December 14th). The final report, which covers issues including eligibility criteria, the protection of vulnerable people and the role of conscientiously objecting health care providers, [can be found here](#).

Recommendations 34-38 deal directly with the role of institutions:

- **Recommendation 34:** All institutions should be required to inform patients/residents of any institutional position on physician-assisted dying, including any and all limits on its provision.
- **Recommendation 35:** Provinces and territories should prohibit any requirements by institutions that patients give up the right to access physician-assisted dying as a condition of admission.
- **Recommendation 36:** Provinces and territories should prohibit any requirement by institutions that physicians refrain from the provision of physician-assisted dying external to the non-participating institution. In addition, employment conditions or privileges should not be negatively impacted in any way.
- **Recommendation 37:** Non faith-based institutions, whether publicly-or privately funded, must not prevent physician-assisted dying from being provided at their facilities.
- **Recommendation 38:** Faith-based institutions must either allow physician-assisted dying within the institution or make arrangements for the safe and timely transfer of the patient to a non-objecting institution for assessment and, potentially, provision of physician-assisted dying. The duty of care must be continuous and non-discriminatory.

Please see Appendix 1 for a full excerpt of these recommendations.

- **Provincial Colleges of Physicians and Surgeons:** It is expected that “much of the heavy lifting” will be done by the provincial Colleges of Physicians and Surgeons, the regulatory bodies that oversee doctors’ work in each province. For example, the College of Physicians and Surgeons of Ontario has interim guidance on physician-assisted dying and is currently [undergoing public consultation](#). In October 2015, the College of Physicians and Surgeons of Manitoba released [a draft statement on doctor-assisted dying](#) for input from the public and its members. The College of Physicians and Surgeons of Saskatchewan recently adopted a [policy on physician-assisted dying](#). Also, on December 15, 2015, New Brunswick’s College of Physicians and Surgeons released [13 guidelines](#) for physicians that will come into effect once the Supreme Court’s deadline expires.

- **Province of Quebec:** In June 2014, Quebec became the first province to pass legislation to legalize physician assisted death, Bill 52, “as part of comprehensive end-of-life legislation.” This legislation came into effect on December 10, 2015, allowing physicians to begin helping patients with an incurable condition and intolerable physical or psychological suffering to die. The regulator for physicians in Quebec, the Collège des médecins du Québec, has developed a guide that shows doctors how to end a patient’s life. They will also be provided with training to provide the life-ending procedure, which could involve nurses and other practitioners.

On Dec. 1, 2015, the Quebec Superior Court issued a court order temporarily suspending the province’s assisted dying law. The Court ruled that the plan violates the federal *Criminal Code* ban on assisted dying (still in effect until Feb. 6, 2016).

However, on December 9th, 2015, Quebec’s highest court [agreed](#) to hear the provincial government’s appeal of the [order to delay the implementation of legal assisted dying](#). Arguments in the case will be heard the week of December 14th, and Quebec is reportedly moving forward with its plan to offering aid in dying starting on December 10, 2015.

Whether the province’s assisted dying provisions remain in effect beyond December 18, 2015, depends on the result of the appeal; as well, the Supreme Court is deciding soon on how it will treat the federal government’s request for a delay of the decision in *Carter vs. Canada*.

- **Canadian Medical Association (CMA):** The Canadian Medical Association has been actively consulting its members and, through the Canadian Medical Forum, other medical stakeholders, including HealthCareCAN (as a member). The CMA has also been consulting the public on the issue of physician-assisted death for more than two years. In July of 2015, the CMA conducted a major consultation with its members about the best framework for providing physician-assisted death.

A challenging question for doctors relates to referral. If a patient requests assisted death, do physicians have an obligation to refer to a doctor who will perform the act? Some physicians see this as morally equivalent to administering a lethal drug. At the 2015 CMA General Council, CMA adopted the position that doctors have to provide “information” to patients. According to Dr. Chris

Simpson, Past-President of CMA, “The challenge is to create rules and regulations that ensure that patients have access to the end-of-life care they want, up to and including hastened death, while ensuring the autonomy of doctors and not forcing them to engage in care that clashes with their religious and moral beliefs.”

Many stakeholders, including the CMA, are calling for federal leadership so that a patchwork of policies imposed by various provincial governments can be avoided.

Despite the above initiatives, there is concern that Canada is not prepared for the fact that physician-assisted death will be legal in Canada on February 6, 2016 (in the absence of an extension from the Supreme Court).

Selected Implications for Hospitals and Healthcare Organizations:

- Much of the focus around the issue has been on the role of physicians. The Supreme Court ruling said nothing about the role of nurses, pharmacists, hospitals, and others in assisted death.
- However, based on the experiences of other jurisdictions, this ruling will have significant implications for hospitals, long-term care facilities, palliative care facilities etc. (where many physician-assisted deaths may occur), and other health professionals (including hospital-based pharmacists and palliative care nurses).
- Canadian hospitals and healthcare organizations are committed to ensuring that patients receive quality end-of-life care, and that treatment wishes are respected.
- HealthCareCAN recognizes the importance of providing resources (including any standardized policies and procedures) that support a coordinated and consistent approach across the country. Clear parameters are needed around the physician-dying process.
- HealthCareCAN also recognizes that there may be challenges for selected hospitals and healthcare organizations with respect to the provision of physician-assisted dying services, as there may be religious, or conscientious objections to participation.
- Consideration needs to be given to implications that might emerge from a scenario where federal law is silent.

- HealthCareCAN is working closely with the Ontario Hospital Association, as well as other members and national associations including the Canadian Medical Association, and the Canadian Society of Hospital Pharmacists.
- HealthCareCAN plans to initiate a consultation process on this issue early in the new year (e.g., a webinar), as we expect to be asked for HealthCareCAN's position by the federal government once Parliament resumes. (As noted above, the federal Parliament has just agreed to establish an all-party Special Joint Committee on physician-assisted dying that will make recommendations on a federal response to the issue). Please contact Jennifer Kitts at Jkitts@healthcarecan.ca to confirm your interest in participating in this national consultation and share any initial issues or concerns that you would like us to specifically address.

Who We are

HealthCareCAN is the national voice of healthcare organizations across Canada. We foster informed and continuous, results-oriented discovery and innovation across the continuum of healthcare. We act with others to enhance the health of the people of Canada; to build the capability for high quality care; and to help ensure value for money in publicly financed, healthcare programs.

Our Vision:

Improved health for the people of Canada through an evidence-based and innovative healthcare system.

Our Mission:

To advance an integrated, innovative, sustainable and accountable healthcare system that provides the people of Canada with a world-leading health system by:

- Being the collective voice of Canada's healthcare organizations;
- Enhancing pathways to innovation;
- Supporting service excellence across the continuum of care; and,
- Developing the health leaders of today and tomorrow.

Appendix I:

Excerpts from the Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying Final Report

November 30, 2015

Role of Institutions Duties of Institutions

All institutions have certain responsibilities in common, many of which align with our recommendations related to physicians.

RECOMMENDATION 34: All institutions should be required to inform patients/residents of any institutional position on physician-assisted dying, including any and all limits on its provision.

This recommendation will ensure that patients have clarity on what is permitted within the facility. They can then make informed decisions with respect to whether to enter or remain in the facility.

RECOMMENDATION 35: Provinces and territories should prohibit any requirement by institutions that patients give up the right to access physician-assisted dying as a condition of admission.

RECOMMENDATION 36: Provinces and territories should prohibit any requirement by institutions that physicians refrain from the provision of physician-assisted dying external to the non-participating institution. In addition, employment conditions or privileges should not be negatively impacted in any way.

Taken together, the two recommendations above limit the power of institutions to restrict the autonomy of patients who may wish to seek physician-assisted dying at a later date, and providers, who may wish to provide physician-assisted dying outside a faith-based institution that does not offer physician-assisted dying. They represent an appropriate balance between patient and physician autonomy, patient access, and institutional autonomy.

Duties of Non Faith-Based Institutions

RECOMMENDATION 37: Non faith-based institutions, whether publicly- or privately-funded, must not prevent physician-assisted dying from being provided at their facilities.

Governments have significantly more levers to influence the policies and practices of institutions that are funded in whole or in part by public funds. However, as a point of principle, we believe that physician-assisted dying should be available wherever people are living and dying. This includes privately-funded institutions. Recognizing that not all institutions will feel capable of providing physician-assisted dying for a variety of reasons, including size, geography and mandate, we concluded that institutions should be permitted to offer a patient transfer to another institution, as long as the receiving institution can and will provide a health care provider who is willing and able to accept the person as a patient, to assess whether the criteria for access to physician-assisted dying have been met, and provide physician-assisted dying where the criteria for access have been met.

Duties of Faith-Based Institutions

RECOMMENDATION 38: Faith-based institutions must either allow physician-assisted dying within the institution or make arrangements for the safe and timely transfer of the patient to a non-objecting institution for assessment and, potentially, provision of physician-assisted dying. The duty of care must be continuous and non-discriminatory.

Faith-based institutions have a duty to care for and not abandon the patients within their institution. While they should not be required to provide access to physician-assisted dying, they must still ensure access for patients who wish to seek it.

When a patient makes a request for physician-assisted dying, faith-based institutions should be required to either allow for the assessment and provision of physician-assisted dying within the institution or make arrangements for an effective transfer of the patient to a non-objecting institution. This transfer must also include the transfer of all relevant records, and must be made to a non-objecting institution where the patient's medical condition can be assessed and treated by a health care provider who is willing and able to assess whether the patient meets the eligibility criteria for physician-assisted dying and, if so, can provide assistance. If a safe and timely transfer to a non-objecting institution is not possible, the objecting institution must allow an outside health care provider to assess the patient and, if the eligibility criteria for physician-assisted dying are met, to provide assistance. The receiving outside health care provider would follow the pathway for physician-assisted dying as outlined previously in this report.

Appendix 2

Selected provisions of Bill 52: An Act respecting end-of-life care (Enacted by Province of Quebec, June 2014)

3. For the purposes of this Act,

(1) “institution” means any institution governed by the Act respecting health services and social services (chapter S-4.2) that operates a local community service centre, a hospital centre or a residential and long-term care centre, as well as the Cree Board of Health and Social Services of James Bay established under the Act respecting health services and social services for Cree Native persons (chapter S-5);

(2) “palliative care hospice” means a community organization that holds an accreditation granted by the Minister under the second paragraph of section 457 of the Act respecting health services and social services and has entered into an agreement with an institution under section 108.3 of that Act in order to secure all or some of the care required by its users;

Special Rules Applicable To Providers Of End-Of-Life Care

§1. — Institutions

7. Every institution must offer end-of-life care and ensure that it is provided to the persons requiring it in continuity and complementarity with any other care that is or has been provided to them.

For this purpose, an institution must, among other things, establish measures to promote a multiple-discipline approach by health and social services professionals and the collaboration of the various other resources concerned who provide services to its users.

8. Every institution must adopt a policy with respect to end-of-life care. The policy must be consistent with ministerial policy directions and be made known to the personnel of the institution, to the health and social services professionals who practise in the institution, and to end-of-life patients and their close relations.

The executive director of the institution must report annually to the board of directors on the carrying out of the policy. The report must include the number of end-of-life patients who received palliative care, the number of

times continuous palliative sedation was administered, the number of requests for medical aid in dying, the number of times such aid was administered as well as the number of times medical aid in dying was not administered, including the reasons it was not administered.

The report must also state, where applicable, the number of times continuous palliative sedation and medical aid in dying were administered at the patient’s home or in the premises of a palliative care hospice by a physician as a physician practising in a centre operated by the institution.

The report is to be published on the website of the institution and sent, not later than 30 June each year, to the Commission sur les soins de fin de vie established under section 38. The institution must include a summary of the report in a separate section of its annual management report.

9. Every institution must include a clinical program for end-of-life care in its organization plan. In the case of an institution that operates a local community service centre, the plan must also include the provision of end-of life care at the patient’s home.

The organization plan must be consistent with ministerial policy directions.

The clinical program for end-of-life care is to be sent to the Commission sur les soins de fin de vie.

10. The code of ethics adopted by an institution under section 233 of the Act respecting health services and social services must have due respect for the rights of end-of-life patients.
11. When an end-of-life patient requests in-home palliative care from an institution, but the person’s condition or environment is such that proper care could not be provided at home, the institution must offer to admit the person to its facilities or direct them to another institution or to a palliative care hospice that can meet their needs.
12. An institution must offer every patient receiving end-of-life care a private room for the final few days preceding the patient’s death.

§2. — Palliative care hospices

13. Palliative care hospices determine the end-of-life care provided in their premises. Every palliative care hospice must inform persons of the end-of-life care it offers before admitting them.

14. A palliative care hospice and an institution must specify in their agreement under section 108.3 of the Act respecting health services and social services the nature of the services the institution is to provide in the premises of the hospice and the monitoring mechanisms that will allow the institution, or one of its boards, councils or committees determined in the agreement, to ensure that quality care is provided in the hospice.

On the request of the institution, the palliative care hospice must communicate any information required for the carrying out of the agreement. The manner in which such information is to be communicated is specified in the agreement.

15. Every palliative care hospice must adopt a code of ethics with respect to the rights of end-of-life patients and adopt a policy with respect to end-of life care.

These documents must be made known to the personnel of the palliative care hospice, to the health and social services professionals who practise in the hospice, and to end-of-life patients and their close relations.

§3. — Private health facilities

16. End-of-life care may be provided at the patient's home by physicians practising in a private health facility within the meaning of section 95 of the Act respecting health services and social services and, within their scope of practice, by nurses practising in such a facility.

Division II Special Functions of Health and Social Services Agencies

17. Every health and social services agency must, after consultation with the institutions and palliative care hospices in its territory, determine the general rules governing access to the end-of-life care provided by those institutions and hospices.
18. Every agency must inform the population living in its territory of the end-of-life care services available and the manner of accessing them, as well as the rights and options of end-of-life patients.

This information must be available on the websites of the agencies.